AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name _____
Date of Birth _____ MRN# _____

I authorize the following entity to release my health information:

_____
_____
_____

The information is to be released to:

Steven C Eggleston, D.C.,
2601 Main Street, Suite 800
Irvine, California 92614
(877) 424-4765 / Fax (877) 883-2963
Email: Dr.Eggleston@yahoo.com

INFORMATION TO BE RELEASED BY THIS AUTHORIZATION

_____ My complete medical records ***after*** _____
_____ Diagnostic imaging films/discs after _____
_____ Diagnostic imaging report(s) after _____
_____ Operative, pathology, EKG and laboratory report(s) after _____
_____ Consultation, history, physical exam and E.R. records after _____
_____ My complete medical records ***before*** _____
_____ My billing statements for services after the date of _____

THE PURPOSE(S) FOR DISCLOSING THIS INFORMATION IS

_____ Review/Inspection of records by Dr. Eggleston
_____ Continuing medical care
_____ Legal purposes
_____ Billing & payment of bill
_____ _____

I understand that the information disclosed by this authorization may be re-disclosed by the recipient and no longer protected by federal privacy regulations.

I hereby give specific authorization to grant the release of mental health diagnosis or treatment. I understand that Welfare & Institutions Code 5328 requires that these mental health records must be treated as confidential.

Initials _____ Date _____

I understand this authorization is voluntary.

I understand that treatment, payment, enrollment, or eligibility for benefits will not be conditioned on signing this authorization except if the authorization is for: (1) conducting research-related treatment; (2) obtaining information in connection with eligibility or enrollment in a health; (3) for determining an entity's obligation to pay a claim; or (4) creating health information to provide to a third party.

I understand that under no circumstances am I required to authorize the release of mental health records unless I specifically authorized the release of such records with my initials above.

I understand that I may revoke this authorization at any time, provided that I do so in writing and submit it to Steven C Eggleston, DC, at the address listed above. The revocation will take effect when received by Steven C Eggleston, DC, except to the extent that Steven C Eggleston, DC or others have already relied on it.

I understand that I am entitled to receive a copy of this authorization and that I may inspect the health information I am being asked to disclose.

Unless otherwise revoked, this authorization expires five (5) years from the date of signing of this form.

It is my intent that a photocopy, scan, email or facsimile copy of this Authorization for Release of Health Information shall be as valid as an original copy.

_____ _____

Signature of Patient Date

_____

Printed Name

_____

(Legal Relationship of Signatory if not Patient)